WORKING TOWARD A MORE COMPETENT HEALTHCARE SYSTEM: A REVIEW

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AUTHORIZATION

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Abstract

In 2000 the World Health Organization (WHO) rated the United States (US) health care system at 15th in overall performance and 1st in overall per capita expenditure. Combining the two ratings left the US ranked at 37th in the world. In 2010, a Commonwealth Fund report ranked the US in last position based on health care quality, efficiency, access, equity and healthy lives. Studies suggest the US system results in inequality, injustice and denial of human rights for some segments of the population. This severely impacts the poor, and studies show that health levels are related to ethnic and racial disparities in access to care. Efforts at reform have produced gains for disadvantaged populations, but no real solutions. This study investigates deficiencies in the US health care system and structural barriers for low income and minority patients, and suggests possible remedies that professional health administrators can pursue to reduce these problems and provide lower costs, better access and better outcomes for these populations going forward.

DEDICATION

To Mom. None of this would be possible without you.

Acknowledgements

I need to thank my adviser Emily Ray and the members of my board Johnna Edmunds and Don Dixon, and also all the professors who gave their time to help me through the master's program at Sonoma University. I also need to recognize the constant support I have received from family, my late grandfather Dillard Smith who raised me, along with my single mother Christine Smith. Thank you to everyone who helped me become the person I am today.

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CHAPTER 1

Introduction

The World Health Organization (WHO) notes that a country's government bears the ultimate responsibility for providing access to health care and maintaining a satisfactory performance in its health care system. This claim is based on the idea of stewardship, where the careful management of resources and population is an indication of good government and a well-functioning society.[1] What a government can accomplish is always limited by the resources available, but because the government needs to support an adequate workforce, public health should always be a priority of government and a public administration concern. This view moves the question of health care into the political arena,[2] and subjects it to the conflicts of pressure groups and party politics in the US government system. This makes it not only a public administration problem, but also a political problem. Any attempt to improve the competence of the US health care system will need to deal with both these sides of the issue.

Background

In the year 2000, the World Health Organization (WHO) released the *World Health Report 2000.*[3] This report included the rankings of health care systems from different countries around the world based on five factors, including: health, health

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[1] WHO, *The World Health Report 2000: Health Systems: Improving Performance,* (Geneva, SZ: World Health Organization, 2000) 120.

[2] Zhu, L. and Clark, J. H., "Rights without Access: The Political Context of Inequality in Health Care Coverage in the U.S. States," *State Politics and Policy,* 15, no. 2 (2015): 239-262.

[3] WHO, *The World Health Report 2000*, 152.

equality, responsiveness, responsiveness equality and fairness of the financial contribution required for service. The report rated the United States (US) health care system at 15th in overall performance and 1st in overall per capita expenditure. Combining the two ratings left the US ranked at 37th in the world. Critics immediately attacked the report, arguing the data was incomplete and out-of-date and that some factors like life expectancy were over-weighted.[4] [5] Supporters of the US system attempted to counter the rating by pointing out the availability of cancer screenings and the high rate of cancer survival, identification and treatment of chronic and psychological disease, advanced research and medical equipment, quality of medical professionals and the opportunities to sue for malpractice when outcomes are poor based on mistakes or negligence of these medical professionals.[6] Perhaps because of the controversy, the WHO did not include rankings in their 2010 health report,[7] but a report that same year from the Commonwealth Fund[8] ranked seven developed countries on health care performance related to quality, efficiency, access, equity and healthy lives. The Commonwealth report placed the US in last position. Regardless, in 2012 Speaker of the House, John Boehner, described the US system as "the best health care delivery system in the world," and Senate Minority

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[4] Whitman, G., *WHO's Fooling Who? The World Health Organization's Problematic Ranking of Health Care Systems*, (Briefing paper 101, Washington, D.C.: Cato Institute, 2008), 1.

[5] Lubin, G., "Ten Reasons Why the US Health Care System is the Envy of the World," *Business Insider*, 2010a.

[6] Ibid, n.p.

[7] WHO, *Health Systems Financing: The Path to Universal Coverage*, (Geneva, SZ: World Health Organization, 2010), 9.

[8] Commonwealth Fund, *U.S. ranks last among seven countries on health system performance based on measures of quality, efficiency, access, equity and healthy lives.* (New York, NY: The Commonwealth Fund, 2010), n.p.

Leader Mitch McConnell also called it "the finest health care system in the world."[9] This indicates a serious disconnect between ratings from world-wide organizations and the political leaders of the US government that is yet to be resolved. (It is possible these leaders have a skewed sense of how health care works in the US because of the guaranteed health care plan they obtain through their positions.) In 2014 Bloomberg released a report that ranked the US system at number 50 out of 55 in efficiency for countries assessed.[10]

In the 2000 report, WHO noted that there are many skilled, dedicated people working in health care: however, health care systems that misuse power and squander potential through poor structure, poor leadership, inefficient organization and inadequate funding can often do more harm than good, leading to unnecessary suffering and large numbers of preventable deaths and disabilities.[11] The 2010 Commonwealth report points out the poor value that US individuals, in general, receive for their dollars because the US system often focuses on profit for the health care practice or organization at the expense of providing good access or outcomes for patients in the system.[12] Part of the problem with for-profit systems is that the payment system results in inequality, injustice and denial of human rights for some segments of the population, severely impacting the poor

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[9] Jacobson, L., "John Boehner says U.S. Health Care System is Best in World," *Politifact*, 2012, n.p..

[10] Du, L. and Lu, W., "U.S. Health-Care System Ranks as One of the Least-Efficient," *Bloomberg Business*, 2016.

[11] WHO, *The World Health Report 2000*, viii.

[12] Commonwealth Fund, *U.S. ranks last among seven countries on health system performance based on measures of quality, efficiency, access, equity and healthy lives.* (New York, NY: The Commonwealth Fund, 2010), n.p.

who have restricted access to high-priced services and medications because of low incomes and lack of health care insurance.[13] [14]

In general, minorities have more problems with access to health care, are in poorer health and are less likely to have health insurance.[15] These problems may have to do with levels of education, income and insurance coverage, but after adjusting for these factors, researchers still find that disparities persist. Possible causes may include local differences in the performance of the health care system, ability of health care providers and barriers to access.[16] The poor also receive lower levels of responsiveness, have fewer choices in providers and treatments and receive fewer amenities. Studies show that levels of infant mortality and early deaths are also related to ethnic and racial disparities in access to care.[17] Because of the increasing diversity of the US population, these disparities mean a larger segment of the population will be at risk for not getting necessary care, which increases structural poverty caused by other related economic and social conditions.[18] This increases social justice problems.

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[13] Farmer, P. "Pathologies of power: Health, human rights, and the new war on the poor." *JAMA*, 6, no. 1(2008): 1-4, doi.org/10.1525/nad.2003.6.1.1.

[14] Fiscella, K., Franks, P., Gold, M.R. and Clancy, C.M. "Inequality in quality: Addressing socioeconomic, racial, and ethnic disparities in health care." *JAMA*, 283, no.19 (2000):2579-2584, doi:10.1001/jama.283.19.2579.

[15] Mead, H., Cartwright-Smith, L., Jones, K., Ramos, C., Siegel, B. and Woods, K., *Racial and Ethnic Disparities in U.S. Health Care: A Chartbook,* (New York, NY: Commonwealth Fund, 2008), 19.

[16] Ibid, 19.

[17] Holland, M. A., Young, M. L. and Jiroutek, M. R., "Racial and Ethnic Disparities in Infant Mortality in North Carolina, 2008–2009," *North Carolina Medical Journal* 77, no. 6 (2016): 373-377.

[18] WHO, *Closing the Gap in a Generation- Health Equity Through Action and the Social Determinants of Health,* (Geneva: World Health Organization, Commission on Social Determinants of Health, 2008), 109.

Statement of Purpose

The purpose of this study is to carry out a critical review of the literature on the causes of reduced access, high costs and poor outcomes in the current US health care system, especially as this affects the structure of economic barriers that keep individuals from moving out of poverty and into higher socioeconomic classes. Additionally, the review will compare how the issues of access, costs and outcomes might be addressed through public administration tools and policy.

If we accept the WHO's premise that a country's government bears the ultimate responsibility for providing access to health care and maintaining a satisfactory performance in its health care system, then public administrators will need to take on an expanded role in shaping policy and dealing with resulting issues. Correspondingly, the goals of this review will be: 1) to determine current findings on the US system's competence, 2) to identify possible solutions to shortcomings within the US health care system that can be solved through administration or policy change and 3) to recommend possible directions for future research.

CHAPTER 2

Methods and Procedures

Literature Search

The author conducted a search of journals, databases, websites and other sources for information on the status of health care in the US, possible other methods of delivering health care and how these other methods might affect the cost and outcomes of health care delivery. The author relied on scholarly resources to provide different perspectives, including journalistic and news sources, source documents like bills and laws, international policy documents and university, government, think tank, and foundation research.

Selection Criteria

The selection criteria for articles included priorities for policy statements and research studies that specifically focused on access, costs and outcomes of the US health care system, with a preference for articles written within the last ten years. The data included both specific and general information on populations and systems. Because the author planned to make recommendations about beneficial changes to the current US system, research focused on studies that showed promise in explaining the reasons behind costs and outcomes and how these might be improved. The research also looked for factual, accurate information of interest in rating health care results and how changes in policy might affect access, costs and outcomes. Only English language documents were reviewed. Eighty-seven documents of the total reviewed met the criteria for inclusion in the references.

Limitations

Because there are such a large number of articles addressing health care, the study made no effort to complete a detailed critique of the methodologies used in the studies and used many of the articles reviewed; however, the study did make an effort to look for any overall methodological issues in the body of literature and for findings that might be useful in analyzing competence of the US healthcare system. The small scope of this study limits the number of articles that could be reviewed within the timeline, which affects the quality of the analysis and conclusions. The exclusion of non-English articles also limits the results.

Research Question

What are the causes, results and possible solutions to limited access, high costs and poor outcomes within the United States health care system, especially as these affect lower socioeconomic groups and racial minorities, and what policy and implementation changes can we make through public administration to reduce these problems?

Significance of the Study

Changes within the US economic landscape caused by the Great Recession and the following jobless recovery increased an already growing lower socioeconomic class of poor and ethnic/racial minorities who have inadequate access to health care. Fueled by economic and political changes, the number of individuals without health insurance peaked in 2013, dropped after the Affordable Care Act was put into effect and then rose again in 2017.[19] One of the key issues in providing for economic mobility is reducing

[19] Luhby, T., "Millions More Americans Were Uninsured in 2017," *CNN Money,* 2018, n.p.

disadvantage, which is caused by a number of problems including poor health. These problems are correlated with lowered ability to gain academic and work skills and, therefore, lowered access to higher-paying jobs or careers.[20] [21] This disadvantage becomes structurally self-perpetrating, meaning that it needs to be addressed and remedied by changes in both government and health care system policy.

Although government has attempted a number of reforms, the current health care system in the US is failing to deal with the structural disadvantage of large numbers of individuals in the system, especially the poor and racial minorities. For this reason, it is important to find workable solutions that will deal with the complex issues involved in providing health care which will lead to better access, lower costs and better outcomes for those affected.[22]

Human Research Subjects/IRB

There will be no human subject research; therefore, no IRB is required for this study.

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[20] Ross, C.E. and Mirowsky, J., "Refining the Association between Education and Health: The Effects of Quantity, Credential, and Selectivity," *Demography* 36, no. 4 (1999): 445-460.

[21] Jackson, S.L., Williams, V., Kotch, J.B., Pahel, B.T. and Lee, J.Y., "Impact of Poor Oral Health on Children's School Attendance and Performance," *American Journal of Public Health* 101, no. 10 (2011): 1900-1906, doi: 10.2105/AJPH.2010.200915.

[22] Fiscella, Franks, Gold and Clancy, "Inequality in Quality."

CHAPTER 3

Literature Review

Brief History of the US Health Care System

In the 1700s, there was little indication of how the current US health care system might take shape. Government involvement during this early period was minimal and public administrators had little or no role in health care.[23] Most people were born with the aid of a midwife and never visited a hospital or saw a doctor. There were no vaccinations, and diseases like measles, smallpox, malaria and poliomyelitis were a common hazard. Infant and child mortality rates were high, and deaths during childbirth were common. Life expectancy was below fifty years, significantly lower than current numbers.[24]

Inoculation for smallpox was introduced beginning in 1716, and medical schools were established in 1765 in Philadelphia and 1768 in New York.[25] The School of Nursing was established in 1884 at Detroit's Harper Hospital. The American Medical Association (AMA) was established in 1847 as a professional organization, which laid the initial foundation for a system that leans mainly to private medical practice rather than to government or public responsibility.[26] With support of the AMA, the US system

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[23] Niles, N. J., *Basics of the U.S. Health Care System, 3rd Edition,* (Burlington, MA: Jones and Bartlett Learning, 2016) 8.

[24] Sultz, H. A. and Young, K. M., *Health Care USA: Understanding Its Organization and Delivery, Seventh Edition*, (Burlington, MA: Jones & Bartlett Learning, 2013), 37.

[25] Niles, *Basics of the U.S. Health Care System, 9.*

[26] Niles, *Basics of the U.S. Health Care System, 9.*

developed mainly through doctors setting up in private, for-profit businesses with prices set by the marketplace.

In 1811 the federal government set up the first medical facility for veterans. In 1887 the National Institute of Health was created as a single room laboratory in the Marine Hospital Service which provided care for merchant seamen who paid $.20 a month for medical service. This provided for a government position in medical research.[27] In 1929 the Baylor Plan laid the groundwork for an employer-sponsored health insurance system with a plan to collect $.50 a month from teachers for health care service, a blueprint that eventually developed into Blue Cross health insurance.[28] During World War II in 1943, President Franklin D. Roosevelt froze labor wages, so companies began to offer benefits like health insurance as an incentive for workers,[29] which led to an expansion of the private health insurance industry. By the 1940s, the AMA was actively defending the system of private physician practice by sponsoring campaigns that set significant barriers to establishment of "socialized medicine," including a national health insurance plan proposed by President Truman.[30] In 1953 the US Health and Human Services (HHS) department was founded. Amendments to the Social Security Act established Medicare and Medicaid, signed into law by President Lyndon B. Johnson in 1965. These were part of Johnson's Great Society plan, and were meant to provide a

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[27] NIH, *A Short History of the National Institute of Health*, (Bethesda, MD: Office of NIH, 2018), n.p.

[28] Niles, *Basics of the U.S. Health Care System, 11.*

[29] Merelli, A. "A history of why the US is the only rich country without universal health care," *Quartz,* 2017, n.p.

[30] Ibid, n.p.

safety net health care system for the elderly and poor. These developments established the US government with major responsibilities in providing for public health care, and greatly expanded the role of public administrators in both developing macro policy and in dealing with individual requirements in public health.[31]

In 1986 President Ronald Reagan signed the Emergency Medical Treatment and Labor Act (EMTALA), which requires hospital emergency departments to provide medical care regardless of a patient's citizenship, legal status or ability to pay charges.[32] This provided for disadvantaged populations with no other access to health care, but led to schemes that transfer costs to other patients and otherwise stress the health care system. For example, static cost shifting charges third party payers different rates for the same services, such as Medicare and Medicaid patients paying lower net prices than private payers. Dynamic cost shifting occurs when hospitals raise prices for some payers because other payers can't pay their bills.[33] Cost shifting increased during the late 1980s after EMTALA was enacted, but cost controls instituted in private insurance plans reduced the practice in the next decade.[34]

In 1986 President Ronald Reagan also signed the Consolidated Omnibus Budget Reconciliation Act (COBRA), which requires employers to offer partially subsidized health insurance to employees who leave employment with the company. In 1996

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[31] Sultz and Young, *Health Care USA*, 37.

[32] Sultz and Young, *Health Care USA*, 42.

[33] Clement, J.P., "Dynamic Cost Shifting in Hospitals: Evidence from the 1980s and 1990s," *Inquiry* 34, no. 4 (1997/98): 340-350.

[34] Sultz and Young, *Health Care USA*, 37.

President Bill Clinton signed the Health Insurance Portability and Accountability Act (HIPAA) into law, which set the standard for protecting medical information, limited health plans' use of pre-existing condition exclusions and prohibited discrimination based on health. In 1987 President Clinton signed the Children's Health Insurance Plan (CHIP), providing health insurance coverage to eight million children of the working poor.[35] This program increased enrollment in public health programs and increased insurance coverage for poor children. It also increased use of medical services by this population, especially for dental services. However, attempts to measure the program's impacts to general health showed mixed results.[36]

In 2003 President George W. Bush signed the Medicare Prescription Drug, Improvement and Modernization Act, creating Medicare Part D which allows Medicare to pay for prescription drugs through private insurance plans. President Bush also called for a portable, universal national electronic health records (EHR) system to organize and consolidate patient records for easy transfer,[37] but in 2019 this system is yet to be developed. In 2010 President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law, again increasing the responsibility of the government and public administrators in providing health care and health care oversight within the US. This law required all US citizens to have health insurance, provided a federal subsidy for the poor, and barred insurers from denying coverage, an attempt to provide better access

[35] Sultz and Young, *Health Care USA,* 51.

[36] Howell, E.M. and Kenney, G.M., "The Impact of the Medicaid/CHIP Expansions on Children: A Synthesis of the Evidence." *Medical Care Research and Review,* 2012. https://doi.org/10.1177/1077558712437245.

[37] Hanson, S. H., "The Problems with the U.S. Healthcare System," *Physicians Practice,* 2017, n.p.

and reduce out-of-pocket costs for low-income and minority populations .[38] Just as President Obama was leaving office, a court ruled federal subsidies for the poor illegal, followed by other court rulings about constitutionality which leave the future of the program uncertain. After his election in 2016, President Donald Trump announced his intention to remove government subsidies for the program, to expand lower cost plans and to eliminate the requirements for universal participation.[39] At this date, Congress has yet to agree on an alternative plan and the ACA remains in effect.

Over its history, the development of a US national health care system has been irregular, and the piecemeal growth has resulted in a disordered structure that often fails to meet public needs. A patchwork of legislation and programs attempts to serve different populations such as low income children, veterans and the uninsured, while the public system struggles to coexist with the for-profit system sustained by political organizations like the AMA. In recent decades the US government has gone a long way toward meeting the requirement for adequate health care as outlined by the WHO.[40] This includes efforts toward universal access and insurance funding for treatment, especially for low-income adults and children, but still the system leaves millions of US citizens without insurance coverage or adequate access to health care providers. Congress seems to be at an impasse, and the issue has become highly politicized. Arguments continue about how to finance increased government involvement in supporting adequate health care, including

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[38] Niles, *Basics of the U.S. Health Care System,* 11.

[39] Glenza, J., "Dismantling Obamacare: What Has Trump Done and Who Will It Affect?" *The Guardian,* 2017, n.p.

[40] WHO, *The World Health Report 2000,* xviii.

proposals for a single-payer system of "Medicare-for-All." The political conflict leaves the role of public administrators uncertain, and they are often caught in the political crossfire of policy development and implementation.

Role of the Public Administrator

In 2019 health care facilities remain primarily operated and owned by private sector businesses, with 21% of hospitals for profit, 58% non-profit and 21% government owned.[41] In 2013 the US government was paying for about 64% of health spending in the US through a variety of programs, including Medicaid, Medicare, Veterans Health Administration and Children's Health Insurance.[42] In 2018 this rose to include almost $700 billion in insurance subsidies for persons under 65 paid through programs like Medicare, Medicaid and the ACA, an amount expected to increase by 15% in 2019.[43] The government also pays for health insurance for public sector employees.[44] These figures show the US government's depth of involvement in the US health care system and indicate the extent of responsibility that public administrators have in managing over half of US health care expenditures.

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[41] AHA, *2017 AHA Annual Survey (FY 2017),* (Chicago, IL: American Hospital Association, 2018) n.p.

[42] Himmelstein, D.U. and Woolhandler, S., "The Current and Projected Taxpayer Shares of US Health Costs," *American Journal of Public Health* 106 (2016): 449–452, doi:10.2105/AJPH.2015.302997.

[43] Ockerman, E., "It Costs $685 Billion a Year to Subsidize U.S. Health Insurance," *Bloomberg,* 2018, n.p.

[44] DPE, *The U.S. Health Care System: An International Perspective*, (Washington, D.C.: Department for Professional Employees, AFL-CIO, 2016) n,p.

There are a number of these socio-economic, socio-political, and socio-cultural determinants that affect health and the social distribution of health.[45] These determinants generate power structures that affect health care cost, access and outcomes at the local, national and global levels. Many of these structures lie outside the health care sector and include both government and private sector organizations.[46] Evidence shows that actions focusing on public policy formulation can have a positive effect on health equity,[47] but good policy by itself cannot be completely successful unless it is actually implemented[48] through appropriate public administration actions. There are generally many layers of both public and private administrators that have roles in policy formulation and implementation, and looking at these roles as they relate to health care can help identify opportunities and challenges in the process of comparing costs and outcomes between health care solutions.

Public administration is generally defined as the organizing, planning, directing, coordinating, and controlling of government operations.[49] This means that where health care or health care policy falls under government operations, public administration comes into play. This includes political situations, because public administration and politics are

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[45] Friel, S. and Marmot, M.G., "Action on the Social Determinants of Health and Health Inequities Goes Global," *Annual Review of Public Health* 32, no. 1 (2011): 225-236.

[46] Ibid, 225.

[47] Carey, G., Crammond, B. and Keast, R., "Creating Change in Government to Address the Social Determinants of Health: How Can Efforts Be Improved?" *BMC Public Health* 14 (2014):1087, doi.org/10.1186/1471-2458-14-1087.

[48] Hill, M. and Hupe, P., *Implementing Public Policy. 2nd Edition,* (Thousand Oaks, CA: SAGE Publications Inc., Thousand Oaks, 2009), 160.

[49] Ibid, 160.

really just different functions of the same entity.[50] Political science/politics and public administration are each paths that individuals can take for public service, but the two paths differ significantly in methodology. Political science is mainly aimed at creating policy and strategy, while public administration is concerned with implementation. This means that public administration has to take make adjustments and create strategies for policies so that they are effective for as much of the population as possible. This also means public administration has to deal with practicalities, or execution rather than theory. A similar relationship exists between public policy, normally created through research, and public administration.[51]

Public administration includes both planning and execution functions, so it includes both policy and action. In the arena of public health, policy generally comes from the workings of politics, while action emerges from the implementation and administration functions of government and includes bargaining and negotiation on how the policy will be put into effect.[52] It is important to realize that politics and administration remain different processes. This dichotomy was first pointed out by Woodrow Wilson, who noted the need to separate political power from administration,

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[50] Meier, K.J. and Hill, G.C., "Bureaucracy in the Twenty-First Century," in *The Oxford Handbook of Public Management*, edited by Ewan Ferlie, Laurence E. Lynn Jr., and Christopher Pollitt, 2009, doi: 10.1093/oxfordhb/9780199226443.003.0004.

[51] Rutgers Staff, "The Difference between Public Administration and Political Science." *Rutgers Online*, 2019.

[52] Barrett, P., "New Development: Risk Management—How to Regain Trust and Confidence in Government," *Public Money & Management* 34, no. 6 (2014): 459-464, doi.org/10.1080/09540962.2014.962376.

which he thought needed to work on a business-like rather than a power-driven basis.[53] Ideological questions, such as how to deal with challenges of fair resource distribution to meet equity goals, generally causes both engagement and interference from the political process.[54] This means that public administrators have to be concerned with effectively working toward equity goals using a layered system that includes both political and non-partisan government structures, plus non-government entities, especially when these goals have to do with costs and access.

Organizational theory looks at human organizations as open systems that interact with their environments, including other organizations.[55] This means they import resources from their external environment, process these through work activities and then export the results back into the external environment.[56] We could look to Frederick Taylor for ways to make the health care process more efficient and cost-effective through standardization and engineering,[57] but this can be a difficult fit for the kind of "wicked," hard to solve problems health care workers deal with. Because organizations are interdependent, this means that public administrators have to deal with a maze of interdependence relationships and how these affect inputs and outputs.[58] These lead to a

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[53] Wilson, W. "The Study of Administration," *Political Science Quarterly*, July 1887.

[54] Hill and Hupe, *Implementing Public Policy.* 63.

[55] Katz, D. and Kahn, R.L., "Organizations and the System Concept," *In Classics of Organization Theory*, edited by Jay M. Shafritz, J. Steven Ott and Yong Suk Jang, 2011: 407-418, Boston, MA: Wadsworth.

[56] Ibid, 407.

[57] Taylor, F. W. *Shop Management,* (New York: Harper and Bros., 1912).

[58] Pfeffer, J. and Salancik, G., "External Control of Organizations: A Resource Dependence Perspective." In *Classics of Organization Theory*, edited by Jay M. Shafritz, J. Steven Ott and Yong Suk Jang, 2011: 449-459, Boston, MA: Wadsworth.

number of central areas of concern for public administrators when dealing with contemporary public health issues. These include: 1) Integrating different parts of government and implement complex policies that cut across related areas like education, welfare and health; 2) crossing boundaries to work effectively with diverse organizations outside government for policy implementation, and 3) setting up partnerships with contractors to achieve the best possible results.[59]

Inter-sectoral collaboration (ISC), highlighted in the 1978 Declaration of Alma-Ata, has been integral to health administration since the 1970-80s. This method of working in public administration follows approaches recommended by health equity research and action.[60] Inter-sectoral collaboration generally refers to cooperation between two or more specialized agencies that perform different roles in health care. This means that multi-sectoral action is necessary but does not necessarily indicate ISC; for example, cases where actions are vertical and related but not collaborative do not qualify.[61] Currently, the WHO promotes inter-sectoral action for health care (IAH) as a method where relationships are formed between health care and other sectors to achieve outcomes that are more efficient, effective or sustainable than those that can be achieved

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[59] O'Flynn, J., Blackman, D. and Halligan, J., *Crossing Boundaries in Public Management and Policy: The International Experience*, (London, UK: Routledge, 2013), 297.

[60] Baum, F., Lawless, A. and Williams, C., "Health in All Policies from International Ideas to Local Implementation: Policies, Systems, and Organizations," In *Health Promotion and the Policy Process: Practical and Critical Theories*, edited by Carole Clavier and Evelyn de Leeuw, (London, UK: Oxford University Press, 2013) doi: 10.1093/acprof:oso/9780199658039.003.0010.

[61] Adeleye, O.M. and Ofili, A.N. "Strengthening Intersectoral Collaboration for Primary Health Care in Developing Countries: Can the Health Sector Play Broader Roles?" *Journal of Environmental Public Health*, 2010, doi: 10.1155/2010/272896.

by just the health care sector working alone.[62] This means IAH is a managed process that is functional, rather than just conceptual, and can be between government agencies, or between government and outside agencies such as non-profit or community-based organizations. [63]

Issues such as health and health equity can never be neatly compartmentalized, which means inter-sectoral approaches are important for developing innovative solutions in dealing with problems. Since the 1980s, three main paradigms or trends have existed within the field of public administration. These include: 1) public administration - where the focus is on administering roles and set guidelines; 2) new public management - where the attention is on cross-sectoral management using leadership from the public sector (a method using markets, contracts and competition to handle resource allocation and delivery of resources), and 3) new public governance (NPG) – where commitment is to collaborative relationships between organizations and policy networks (a method focusing mainly on institutional relationships). [64]

Weber and Khademian note the advantages of networks in working with the "wicked problem" of health care, or problems impossible to completely solve because of social complexities, interdependencies and often contradictory requirements. These networks are often effectively used to solve short-run problems, create learning opportunities and share resources and goals between different organizations. However,

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[62] WHO. *Intersectoral Action: An Analysis of 18 Country Case Studies.* (Geneva, SZ: World Health Organization, 2008) 12.

[63] Adeleye and Ofili, "Strengthening Intersectoral Collaboration," n.p.

[64] Osborne, S., *The New Public Governance: Emerging Perspectives on the Theory and Practice of Public Governance*, (London: Routledge, 2010), 17.

the authors also point out that networks present challenges for managers working within this framework of collaboration. In particular, the authors note that sharing of knowledge is vital in working through challenges effectively, and propose that managers, using their strategies, skills and tools, are key to building collaborative capacity. The authors propose more research on the role of these managers to help clarify what strategies and tools are most effective.[65]

The diversity of health care networks means that successful public administrators have to focus on creating approaches and arrangements that support accountability, communication and sustainable outcomes.[66] This working area has a lot of potential for interventions upstream to negotiate relationships across government organizations; for example, different public administration systems such as health care and education often hold different values that can impede cooperation in solving problems downstream. This focus also emphasizes relational skills in public service leadership, which are important in creating a networked environment. These skills include problem solving, coordination, brokering and flexibility, which are also critical for working toward effective policy change.[67] At the current date, the fields of public administration and public health remain mostly separate, but an increasing debate about health politics means the two fields are

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[65] Weber, E.P. and Khademian, A.M., "Wicked Problems, Knowledge Challenges, and Collaborative Capacity Builders in Network Settings," *Public Administration Review*, 68, no. 2 (2008), doi.org/10.1111/j.1540-6210.2007.00866.x.

[66] Osborne, *The New Public Governance,* 125.

[67] Dickinson, H. and Sullivan, H., "Towards a General Theory of Collaborative Performance: The Importance of Efficacy and Agency," *Public Administration* 92, no.1 (2014): 161-177, doi.org/10.1111/padm.12048.

shifting towards one another.[68] This shift provides an opportunity for an expanded role for public administrators in the health care field, and greater engagement of public administrators' skills in studying and solving problems within the health care industry.

Public administration and health care interface in different ways.[69] First, public administrators play an important role in oversight of the medical industry. Public administrators work for the federal government in enforcing laws that relate to health care, and also make sure legislation is working as expected. Public administrators also work with doctors and other health care professionals to make sure organizations are following laws and regulations as required, a role that becomes more important as the burden of government regulations becomes increasingly harder for health practitioners to handle; for example, the Centers for Medicare & Medicaid Services (CMS) keep health care practitioners up-to-date on changes to requirements for these programs, and the Veterans Administration oversees the Veterans Choice Program (VCP). Another important role for public administrators is in policy formulation. Because public administrators in the field have important knowledge about the health care system, they can act as experts to supply analysis and advice for lawmakers on writing, amending or repealing laws related to health care.[70]

Deborah Stone recommends a model with four criteria for setting public policy goals. These include: equity, efficiency, security and liberty. These concepts are always

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[68] De Leeuw, E., Clavier, C. and Breton, E. "Health policy – Why Research It and How: Health Political Science," *Health Research Policy and Systems*12 (2014): 55, doi.org/10.1186/1478-4505-12-55.

[69] Ohio University, *The Role of a Public Administrator in the Health Industry,* (Athens, OH: Ohio University, 2018).

[70] Ibid, n.p.

subject to negotiation and reinterpretation during the construction of solutions, but Stone cautions that no one interpretation will provide a simple solution to any constantly shifting wicked problem like health care.[71] A number of other promising new models for health care delivery have emerged in the last few years, which include comparative effectiveness analysis, evidence-based medicine, patient-centered medical homes, and innovative delivery systems paired with financial incentives.[72] Administrative research and methods can assist with identifying contexts within these models that public health advocates can use to help create change.[73] Through the role of administration in dealing with health care costs, access and outcomes, we can use our particular talents to affect the structural determinants of health care inequities embedded in the current US system where politics, economics and social policies so often seem misaligned with health equity. However, making these changes means fostering an awareness of equity goals.

Accountability

The principle of accountability holds individuals and organizations responsible for their actions.[74] Establishing accountability in public administration of health care is a difficult problem because of the number of different stakeholders, organizations and institutions involved in the health care system. Examples of some these players include

[71] Stone, D.A. *Policy Paradox: The Art of Political Decision Making*. (New York: Norton, 2002).

[72] Mukamel, D.B., Haeder, S.F. and Weimer, D.L., "Top-Down and Bottom-Up Approaches to Health Care Quality: The Impacts of Regulation and Report Cards," *Annual Review of Public Health*, 35 (2014): 477-497.

[73] Carey, G., Crammond, B. and Keast, R., "Creating change in government to address the social determinants of health: how can efforts be improved?" *BMC Public Health* 14 (2014):1087, doi.org/10.1186/1471-2458-14-1087.

[74] IOM, *For the Public's Health: The Role of Measurement in Action and Accountability*, (Washington, DC: The National Academies Press, 2011), doi.org/10.17226/13005.

government public health personnel, clinical care providers, employers that offer health coverage, and individuals who use the system. Many of these stakeholders have a poor understanding of their role in providing for a community's level of health and well-being, and pathways for responsibility are not easily traceable.[75] One approach to dealing with these stakeholders is in the work of R. Edward Freeman, which provides methods to identify and model groups of stakeholders in order to best consider their interests. In other words, a program needs to provide value for all stakeholders before it can be considered successful, and in particular, it needs to maximize value for the intended recipients.[76]

Better accountability has recently become the focus of government with the adoption of

New Public Governance practice.[77] One of the requirements of this approach is to ensure a method of accountability, and to make sure government periodically evaluates the performance of all public administrators. Accountability in public administration is important because of democratic principles, which hold elected officials and their employees responsible for policies and outcomes that use public funds and affect the voting public.[78] This means that when a public administrator is entrusted with a responsibility, he or she is expected to perform to the best of their ability. If outcomes are poor, then the public employee needs to be able to explain where the policy or actions

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[75] Ibid, n.p.

[76] Freeman, R.E., *Strategic Management: A Stakeholder Approach.* (Boston: Pitman, 1984).

[77] Osborne, *The New Public Governance*, 36.

[78] Sultz and Young, *Health Care USA,* 150.

went wrong. The idea that failures require an explanation is an important part of accountability that establishes a balance between government and public interests in the system.[79]

A practice of demonstrating results and effectiveness to the public is a fairly new standard in this area of governance, but there has been a clear movement toward establishing greater accountability within government-funded health care programs. The Institute of Medicine (IOM), for example, now provides reports on federal quality initiatives and quality of service for the Centers for Medicaid and Medicare Services (CMS). The National Committee for Quality Assurance has set quality measures, and the National Quality Forum has made efforts to set US national priorities and standards for performance in clinical care.[80]

Studies in reforming health care systems show that system-wide accountability can be hard to achieve. Transformation of funds and insurance coverage into cost-effective service is often hindered by inefficiencies, waste, poor-quality service and poor distribution and scarcity of qualified workers.[81] Although many of Frederick Taylor's practices are a difficult fit for individualized health care, we would do well to note his two basic observations about poorly performing processes: 1) unevenness in management and 2) a lack of relationship between the results of management and dividends.[82]

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[79] Ibid., 150.

[80] IOM, *For the Public's Health,* Appendix F.

[81] Yip, W. C., Hsiao, W. C., Chen, W., Hu, S., Ma, J. and Maynard, A., "Early Appraisal of China's Huge and Complex Health-care Reforms," *The Lancet* 379, no. 9818 (2002): 833-842, doi.org/10.1016/S0140-6736(11)61880-1.

[82] Taylor, *Shop Management,* 1.

Accordingly, in order to make the necessary changes for accountability, governments need to improve management of government-funded hospitals, institute appropriate regulation, and reform incentives for providers. As examples of reforms like this currently in work, in 2018 the CMS proposed changing Medicare fees for doctors, reducing the amount of paperwork required for billing,[83] and adjusting drug prices.[84] Changes like these could be obstructed by stakeholders and low implementation capacity, and research suggests that independent, outcome-based evaluation may be necessary to make providers and officials more accountable.[85]

Mukamel, Haeder and Weimer note that poor quality in health care results has led to two main methods of public policy response. The first is regulation, which is a top-down approach to reform including requirements such as licensing and certification, and the second is report cards, a bottom-up approach to accountability where data on process and outcomes is provided to a third-party evaluator. The authors' research suggests that both methods can result in changes which are difficult to predict, and that both may actually decrease quality of care if not properly implemented. They found there was insufficient data, especially cost data, to determine which would be a better fit for given circumstances.[86] Other models have been offered and research suggests the simplest

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[83] Bebinger, M., "Some Doctors, Patients Balk at Medicare's 'Flat Fee' Payment Proposal," *NPR*, 2018, n.p.

[84] Roy, A., "Trump's Dramatic New Proposal to Lower Medicare Drug Prices by Linking to an International Index*," Forbes,* 2018, n.p.

[85] Yip, W C., Hsiao, W C., Chen, W., Hu, S., Ma, J. and Maynard, A., "Early Appraisal of China's Huge and Complex Health-care Reforms," *The Lancet* 379, no. 9818 (2002): 833-842, doi.org/10.1016/S0140-6736(11)61880-1.

[86] Mukamel, Haeder and Weimer, "Top-Down and Bottom-Up Approaches to Health Care Quality": n.p.

method for establishing accountability could be to link all inputs such as capacity, resources, processes, policies and interventions with outputs like immediate and long-term outcomes. There are a number of problems with establishing this kind of evaluation system, but public administrators should note that accountability in this kind of model is closely linked with planning, needs assessment and clear priorities. All these are actions that need to be taken at the beginning of any process and monitored during its implementation.[87]

US Health Care Problems

Starfield appraised data on the US health care system in relation to claims by US politicians that it is the "best in the world."[88] Examining the results, the author notes a number of visible problems that exist within the system, such as: Over 40 million people have no health insurance coverage at all. High costs are apparently tolerated with the expectation this will provide better care in spite of evidence that shows 20-30% of patients receive unnecessary or contraindicated care.[89] A 1999 Institute of Medicine (IOM) report shows that 44,000-98,000 US Americans die as a result of medical errors each year, many of which are preventable. Starfield suggests the following should be investigated for negative effects on the quality of US health care: 1) The primary provider versus specialist organization of US health care; 2) illness caused by medical examination

[87] IOM, *For the Public's Health*, Appendix F.

[88] Jacobson, L., "John Boehner says U.S. Health Care System is Best in World," *Politifact*, 2012, n.p.

[89] Starfield, B., "Is US Health Really the Best in the World?" *JAMA* 284, no. 4 (2000): 483-485, doi:10.1001/jama.284.4.483.

and/or treatment; and 3) income inequality and social disadvantage as it interfaces with the health care system.[90]

Lubin[91] lists areas where the US health care system rates as inferior to other systems. These include: 1) High per capita spending on health. 2) Health care premiums that rise much faster than inflation. 3) Patient complaints that doctors do not spend enough time with them. 4) Only 30% of US doctors use electronic records, compared to 90% in Europe. 5) Only about 30% of US doctors are paid based on performance. 6) More than 40% of US Americans can't pay their medical bills. 7) Demands on emergency rooms continually increase because of uninsured patients. 8) 20% of US Americans report medical errors and 195,000 people die of medical errors annually. 9) Doctors spend $200 billion annually on unnecessary procedures to reduce their liability. 10) Practitioners treat high percentages of women and children with antidepressants. 11) The US has the highest child mortality rate of the top 20 developed countries. 12) Prescription drugs cost about 50% more than other developed countries, while 25% of US Americans report they cannot pay for prescriptions. 13) Inefficiency costs $200 billion annually (e.g. Medicare operates with 3% overhead, while private insurance costs are 26%). 14) The US has high rates of chronic disease, accounting for 91% of expenditures. 15) Minorities have lower access to health care. 16) 22% of US patients reported their test results or other records were not available during their medical appointments.[92] These

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[90] Ibid, 483.

[91] Lubin, G., "50 Depressing Facts about the Healthcare System that Will Make You Beg for Reform," *Business Insider*, 2010b, n.p.

[92] Lubin, G., "50 Depressing Facts," n.p.

deficiencies Lubin reports relate directly to the low ratings of the US health care system achieves on quality of service for per capita costs, and suggest an outline of what needs to be done to improve the system.

Dougherty and Conway note that the US continues to provide significant investment in science and clinical research with impressive results. However, due to a systematic failure to get these results to patients in a timely fashion, the US struggles to provide improved health outcomes and high-quality care. In 2005 expenditures on US health care were in excess of $6,000 per capita, without improved outcomes, a figure which rose to over $10,000 per capita in 2018. The authors note that the country will continue to fail leverage of new clinical research into improved health care without a stronger model to improve the pace of innovation in clinical settings.[93]

Writing in *Physicians Practice,* Stephen Hanson blames problems in quality and delivery in the US health care system on for-profit motives and mandatory, inefficient electronic health records systems that use up large amounts of provider time and resources. This results in high administrative costs and a system driven by billing software, rather than the needs of the patient.[94] In another article, Houston calls this issue a problem with "medical Taylorism," where doctors are allowed limited time to spend with patients and are required to answer standardized questions that do little to describe the patient's complaint. [95] A study of Veterans Administration patients in dual health care

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[93] Dougherty, D. and Conway, P.H., "The '3T's' Road Map to Transform US Health Care: The 'How' of High-quality Care," *JAMA* 299, no. 19 (2008): 2319–2321, doi:10.1001/jama.299.19.2319.

[94] Hanson, S. H., "The Problems with the U.S. Healthcare System," *Physicians Practice,* 2017, n.p.

[95] Houston, M., "Has Medical Taylorism gone too far?" *Irish Medical Times,* April (2016), n.p.

programs notes that non-VA providers have frustrating problems in accessing records and making referrals into the VA system.[96]

Zimlichman notes that health care-associated infections (HAIs) cause significant threats to patient health and lead to high costs. Recent studies have indicated that at least 50% of these infections are preventable. Reform initiatives have produced some gains, but both harm and costs continue to be high. In this study the researchers found total costs of the five major infections were $9.8 billion. These included bloodstream infections, ventilator-associated pneumonia, surgical site infections, Clostridium difficile infections, and catheter-associated urinary tract infections. Surgical site infections caused about 34% of the total costs, followed by ventilator-associated pneumonia at about 32%. Bloodstream infections caused about 19%, C. difficile caused about 15%, and catheter-associated urinary tract infections caused less than1%. Prevention of these HAIs with specific safe practices is a key opportunity for professionals seeking to improve US health care. If hospitals can realize savings from prevention, they may be more likely to invest in effective strategies.[97] Reducing hospital-acquired infections would reduce costs in the system and improve the outcomes for patients with chronic illnesses that need frequent hospital services.

Berwick and Hackbarth note an urgent need to provide US health care costs in a sustainable range for both private and public clients. Usual programs to cut costs include reductions in payments, eligibility and benefits, when reduction of waste would be a

[96] Pope, C.A., Davis, B.H. and Wine, L. "Perceptions of U.S. Veterans Affairs and community healthcare providers regarding cross-system care for heart failure," *Sage* 14, no. 4 (2018): 283-296, doi.org/10.1177/1742395317729887.

[97] Zimlichman, et al., "Health Care–associated Infections," 2019.

more effective and less harmful strategy. The authors list categories of waste as: overtreatment, coordination failures, execution of care process failures, complexity of administration, pricing issues, fraud and abuse. The lowest estimated cost the researchers found for this waste amounted to 20% of health care costs. The authors note that savings from even a fractional reduction in waste would be higher than cuts in coverage and care. However, they also note that economic dislocations from this process might be severe and would require careful management.[98]

Peabody looked at efforts at reform. Economic reform policies and structural adjustment programs are generally viewed as short-term austerities that will lead to better long term outcomes. However, this kind of trade-off is not always acceptable in health care, where some biological events cannot be postponed. Health care policy makers need a better understanding of the impacts of economic reform on individual health outcomes, which they can gain by looking at the recent experience of developing countries. When health care budgets suffer from reduced government spending, nutrition, cost-effective preventive programs and quality of care all deteriorate due to mismatches of labor and capital. Although overall health outcomes may not appear to suffer, a more detailed look at data shows the incidence of preventable disease rises, and health status may decline irreversibly. To prevent this, health policymakers need to maintain a multidisciplinary focus on understanding the effects of reform efforts and plan a coordinated response to

[98] Berwick and Hackbarth, "Eliminating Waste," 1513.

the resulting problems. Peabody recommends alternative financing for health care, better data and strong political leadership to effectively conduct health care reform.[99]

Reinhardt, Hussey and Anderson explored reasons for high US health spending on health care as compared to other countries (some with older populations) using the most recent data on spending from the Organization for Economic Cooperation and Development (OECD). Reasons they identified for the high expenditures include: a higher US per capita gross domestic product (GDP), a fragmented and complex payment system, and high administrative costs. The authors also investigated the burden health care spending puts on the US economy, and looked at efforts by US policymakers to increase prices that other world health care systems pay for US pharmaceuticals.[100]

Structural Inequities

High medical costs can contribute to poverty. McIntyre, Thiede, Dahlgren and Whitehead conducted a critical review of studies, focusing on the economic consequences of illness and health care use on low and middle-income countries. These consequences include direct costs related to medical treatment and indirect costs like loss of productivity and household response in the wake of illness. The study points out that financing methods placing emphasis on out-of-pocket payments can push households into poverty or deeper poverty. Reforms since the 1980s have focused on user fees for public sector services and increasing use of the private for-profit sector in provision of health

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[99] Peabody, J. W., "Economic Reform and Health Sector Policy: Lessons from Structural Adjustment Programs," *Social Science & Medicine* 43, no. 5 (1996): 823-835, doi.org/10.1016/0277-9536(96)00127-X.

[100] Reinhardt, U.E., Hussey, P.S. and Anderson, G.F., "U.S. Health Care Spending in an International Context," *Health Affairs* 23, no. 3 (2004): n.p., doi.org/10.1377/hlthaff.23.3.10.

care. This has increased the cost burden on individuals with health problems. The trend continues worldwide, even though some international organizations are shifting away from user-fee systems. There is an urgent need for alternative health care funding strategies and mechanisms to cope with both the direct and indirect costs of illness in order to provide policymakers with tools to improve the necessary access to essential health services for the poor.[101]

Blaxter conducted a review of health care as a defense against the consequences of poverty, asking the questions: Are disadvantages mainly because of inequality or poverty? Are disadvantages behavioral or structural? The author looked at the role of health services in relation to primary prevention, secondary or curative medical prevention, and tertiary or rehabilitative prevention, and found that disadvantage was related to both environmental (structural) and individual (lifestyle) factors. She concludes that health care systems in industrialized nations have not been generally successful in mitigating or preventing the health problems associated with poverty. However, some delivery systems have produced promising results. While increasing health care services can never fully repair social inequalities in health, community-based health programs have the potential to produce improvements in the health of low-income and minority populations.[102]

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[101] McIntyre, D., Thiede, M., Dahlgren, G. and Whitehead, M., "What Are the Economic Consequences for Households of Illness and of Paying for Health Care in Low- and Middle-income Country Contexts?" *Social Science & Medicine* 62, no. 4 (2006): 858-865, doi.org/10.1016/j.socscimed.2005.07.001.

[102] Blaxter, M., "Health Services as a Defense against the Consequences of Poverty in Industrialised Societies," *Social Science & Medicine* 17, no. 16 (1983): 1139-1148, doi.org/10.1016/0277-9536(83)90006-0.

Poor prenatal care can lead to higher infant mortality. Although national rates of infant mortality have declined over recent decades, research shows the US southeastern states continue to lead the country in infant mortality. He, et al. studied the differences in these states from 2005-2009 and found that mothers with no prenatal care experienced the highest infant death rate (about 5282 per 100,000 in Mississippi and about 4261 per 100,000 in Louisiana). Poor living standards and low education levels might also be significant as causes for these high rates of infant mortality.[103] African American women, in particular, seem to experience more harmful effects from structural poverty. Prather, Fuller, Marshall and Jeffries investigated the effects of racism on African America women's health and recommended that public health departments are well placed to develop strategies for successful intervention. The authors recommended community-level programs to reduce African American women's risk for sexual and reproductive health problems, along with programs to increase educational and employment opportunities, as a method to reduce the socio-economic determinants that lead to structural poverty.[104]

Fiscella, Franks, Gold and Clancy note that a for-profit system contributes to racial and ethnic disparities in health care: in general, individuals of lower education, occupational status and income experience worse health and have shorter lifespans than individuals who are better off. The authors reviewed racial and ethnic disparities in

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[103] He, X., Akil, L. Aker, W.G., Hwang, H. and Ahmad, H.A., "Trends in Infant Mortality in United States: A Brief Study of the Southeastern States from 2005–2009," *International Journal of Environmental Research and Public Health* 12, no. 5 (2015): 4908–4920, doi: 10.3390/ijerph12050490.

[104] Prather, C., Fuller, T.R., Marshall, K. J. and Jeffries, W. L., "The Impact of Racism on the Sexual and Reproductive Health of African American Women," *Journal of Women's Health* 25, no. 7 (2016): 664–671.

quality of health care and found there has been little progress in monitoring efforts to reduce this disparity through organizational quality improvement. The authors discuss the limitations in existing quality assessment instruments for monitoring these disparities and propose five methods for tracking: 1) Identify disparities as a significant quality problem. 2) Improve current data collection efforts. 3) Stratify clinical performance measures by race, ethnicity and socioeconomic position for public reporting. 4) Monitor the health care population with adjustments for race, ethnicity and socio-economic position. 5) Form strategies to adjust payment for race, ethnicity and socio-economic position because of the effects of these factors on morbidity.[105]

Poor levels of education are related to poor health. Ross and Mirowsky studied the well-established association between education level and health by investigating credentials, selectivity and quantity of education, plus examining mechanisms that might correlate these with health. The results of the study show that perceived health and physical function increase significantly with years of education and with college selectivity for individuals with a bachelor's degree or higher. A big part of the net association of college selectivity with perceived health and physical functioning looked to be related to health lifestyle.[106] This finding suggests that the poor suffer doubly from low education levels related to their disadvantage, both in lowered family income and in lowered health status due to lifestyle. High costs for health care cause an additional drain

[105] Fiscella, K., Franks, P., Gold, M.R. and Clancy, C.M., "Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care," *JAMA* 283, no. 19 (2000): 2579-2584, doi:10.1001/jama.283.19.2579.

[106] Ross and Mirowsky, "Refining the Association between Education and Health," 445.

on resources for these individuals or families, reduce their access to care because of inability to pay for it, and lead to worse outcomes because of lack of care.

A major crisis in the health care system is the problem of providing health care to the homeless and/or drug addicted.[107] The Substance Abuse and Mental Health Services Administration estimated in 2003 that 38% of the homeless were dependent on alcohol and 26% on other drugs. Many do not receive treatment because of high costs and lack of medical insurance. Other barriers to treatment include no transportation, long waiting lists and poor or no documentation. Few programs provide funds specifically for the homeless population. Programs need substance abuse treatment combined with housing opportunities and services for mental health treatment, physical health care, peer support, education, employment assistance and daily living skills.[108]

Ways to Make Improvements

Socioeconomic and racial/ethnic disparities in health care and health status are a continuing policy concern in the US. Much of policy focuses on improvement in coverage, access, intensity and quality of health care. However, studies show that health is more a function of lifestyle and living and working conditions than care. Because of this, efforts to improve health and reduce gaps in health care need to look at social determinants both without and within the health care system, including poverty and disadvantage. Williams, Costa, Odunlami and Mohammed reviewed research on the social determinants of health as a means to reduce health disparities, and focused on

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[107] NCH, *Substance Abuse and Homelessness,* (Washington, D.C.: National Coalition for the Homeless, 2019), n.p.

[108] Ibid., n.p.

interventions that can address some of these social determinants from without and within the health care system. These include improvements in neighborhood conditions, housing, and better socioeconomic levels. The authors point out the importance of systematic evaluation of economic and social policies that could have health benefits or consequences, and the need for healthcare providers, policy makers and leaders in multiple societal sectors to apply available knowledge to improve the underlying conditions of poor health.[109]

Community-based programs as recommended by Blaxter[110] include initiatives such as the Healthy Communities Program and the REACH U.S. programs, both funded by the Centers for Disease Control and Prevention (CDC) that help communities set policies and identify factors that will reduce the burdens of poor resident health on community resources. These health initiatives target environmental factors, obesity and chronic disease, and encourage people to practice health management and good nutrition, to avoid substance abuse and to exercise regularly. The REACH program, especially, was founded with the goal of reducing ethnic and racial health disparities in the US. These programs have been shown to reduce health care costs, but early adoption rates were found to be low.[111] A 2008 Trust for America's Health study found that investing about $10 per year per person in US community-based health programs could save more than

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[109] Williams, D.R., Costa, M.V. Odunlami, A.O. and Mohammed, S.A., "Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Health and Reduce Disparities," *Journal of Public Health Management Practice* 14 (2008): S8-17, doi:10.1097/01.PHH.0000338382.36695.42.

[110] Blaxter, "Health Services as a Defense," 1145.

[111] Trust for America's Health, *Examples of Successful Community-based Public Health Interventions (State-by-State),* (Washington, DC: Trust for America's Health, 2009), n.p.

$16 billion annually after the first five years. This included an annual estimated $5 billion for Medicare, $1.9 billion for Medicaid and $9 billion for private payers.[112]

Betancourt, Green and Carrillo developed a definition of "cultural competence" as a strategy, reviewed literature, identified key components for interventions, and built a practical framework of measures to address ethnic and racial disparities in health care. The researchers identified socio-cultural barriers to care, levels where these barriers occur and cultural competence methods to address the identified barriers. Socio-cultural barriers to care were found at the organizational, structural and clinical levels. At the organizational level, these include leadership and workforce barriers such as fewer minorities within the healthcare field. At the structural level, these include processes of care when patients have to deal with complex systems without assistance or translation services and get stuck with long waiting times in a bureaucratic process. At the clinical level, these include provider-patient encounters where providers and patients from different ethnic backgrounds may have different perspectives on what treatment is expected or required. To address these barriers, the authors recommend a framework of cultural competence interventions including minority recruitment into health care careers, interpreter services, translated educational materials and provider education on cross-cultural issues.[113]

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[112] Trust for America's Health, *Prevention for a Healthier America,* (Washington, DC: Trust for America's Health, 2008), n.p.

[113] Betancourt, J.R., Green, A.R. and Carrillo, J.E., "Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care." *Public Health Reports,* 118, no. 4 (2003): 293-302, doi.org/10.1093/phr/118.4.293.

Woolhandler and Himmelstein investigated four components of administrative costs, including hospital administration, insurance overhead, nursing home administration and physician expenses for billing and overhead. Data came from federal statistics and health agencies and published sources. Between 1983 and 1987, administrative costs increased by 37% in the US, while they declined under other systems. This left administrative spending 117% higher in the US than Canada, for example, accounting for about half the difference in total health care spending between the two countries. The researchers note that the administrative structure of the US system has been complicated by bureaucratic and cost-containment requirements. In the US, clerical/managerial staff account for approximately 60% of non-physician employees, while technicians account for less than 10%. Staff spent about one hour on each insurance or Medicare claim in the US, about 20 times more than in a single-payer system like Canada's. The system of multiple payers in the US increases bureaucratic costs, as do regulations on coverage, eligibility and documentation. In addition, billing on a per-patient basis requires extensive accounting. In contrast, a single-payer system would eliminate almost all hospital billing.[114] However, the Canadian system struggles with high costs and long waiting times, and even twenty years ago was under strain and looking at more market-based solutions.[115]

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[114] Woolhandler, S. and Himmelstein, D. U., "The Deteriorating Administrative Efficiency of the US Health Care System." *New England Journal of Medicine,* 324 (1991): 1253-1258, doi: 10.1056/NEJM199105023241805.

[115] Deber, R. B., "Canadian Medicare: Can It Work in the United States-Will It Survive in Canada," *American Journal of Law and Medicine,* 1993.

In 2018 Pollin, et al. studied the economic impact of implementing a Medicare-for-All system in the US, including coverage for pharmaceuticals. The authors note that this would be expected to increase demand for health care services by about 12%, as currently some segments of the population are underserved. Cost savings would be expected to be about 19% over the current system, mostly through cuts in administrative requirements, regulation of pharmaceutical prices and reduction of waste. Taking current government costs into account, Pollin, et al. posit that an additional $1.05 trillion would be needed to finance the system, which they suggest could be raised through additional taxes on businesses, sales, net worth and capital gains. The authors also note that there would be "formidable challenges" in implementing this system, as it would involve: 1) a huge administrative transition; 2) impact on physician incomes and therefore the supply of health care workers available to meet the increased demand; and 3) the undermining of large companies and displacement of workers in both the health services and private health insurance industries. Although the authors recommend the net benefits of a single-payer system for the US, they also note that these economic issues would need to be carefully managed.[116]

Goldman and Leive conducted an analysis of Medicare-for-All proposals and noted that arguments in favor generally make three claims: 1) Medicare pays lower prices; 2) Medicare has lower administrative costs; and 3) current higher spending in the US has not resulted in better health for its residents. Regarding prices, the authors' analysis found that lower prices in a single-payer system are based on monopsony buying

[116] Pollin, R., Heintz, J., Arno, P., Wicks-Lim, J. and Ash, M., *Economic Analysis of Medicare for All,* (Amherst, MA: Political Economy Research Institute, University of Massachusetts, 2018).

power, which regulates payments and leads to health care workers leaving the system in search of better income. This has already been demonstrated in the Medicaid system, where physician practices exit the system when payments are too low. Regarding administrative costs, studies have shown wide variations in the administrative costs for Medicare, and analysis suggest that lower costs provide less incentive to regulate overuse of medical services. Regarding US spending, the market economy and levels of spending do provide some benefits for US residents, including development of innovative pharmaceuticals and medical technology, and improved survival rates for cancer which are unrelated to Medicare coverage. The authors also point out the high levels of fraud that exist within the current Medicare system as a disadvantage.[117]

CHAPTER 4

Discussion

This research points out the complexity of the problems in the US health care system, and the challenges to improving the system to provide lower costs, better access and better outcomes for low-income and minority patients. Constantly rising costs emerge as a major barrier to extending national insurance coverage, along with the challenges of a more diverse population and the opposition of special interest groups

[117] Goldman, D.P. and Leive, A. "Why 'Medicare-For-All' Is Not The Answer," *Health Affairs*, 2013.

within the US medical and insurance industries.[118] The for-profit US system continues to have numerous problems, including high administrative costs and complexity, inequity in access and often low quality outcomes. As a result, the economically disadvantaged often have unaddressed health problems that contribute to their disadvantage.

These issues offer a number of opportunities for improvement, especially in the area of equity for all. However, health care is a wicked problem, impossible to completely solve because of contradictory needs and constantly changing requirements. This means expectations for any kind of easy solution to the structural disadvantage in health care, including a single-payer Medicare-for-All system, are likely doomed to failure. Medicare-for-All has recently been proposed as a solution to insurance coverage problems in the US health care system. An in-depth analysis of this type system is out of the scope of this paper, but examination of the proposals suggests that simplifying the administration of health care with a single-payer system will not result in enough cost savings to make the program affordable for US taxpayers and is likely to reduce the number of providers.[119] In this case, services would require deep cuts to make the program workable. Rather than looking at a single policy solution, adaptive local solutions based on conditions, needs and market opportunities might work out as a better method of dealing with the challenges.

Studies in underdeveloped countries show how clean water, sanitation, housing, education and nutrition affect levels of infectious and communicable diseases. These

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[118] Lewis, M., "Can the U.S. Health Care System Be Fixed? – History, Problems & Solutions," *Money Crashers,* 2019.

[119] Pollin, et al., *Economic Analysis of Medicare for All,* 2.

factors in disease levels are all dependent on income—the lower the income, the poorer the living conditions and the higher the rates of disease. Handouts to the poor to increase their real income or to meet "basic needs" do not take the underlying factors into account, which means they will always be limited in effectiveness for permanently raising the socio-economic levels and improving living conditions. A country's elite determines the role of the government and, to defend their own positions, the elite are only willing to provide a certain amount of charity. The only cure for this problem is a government that works for the majority of people, and not just for a small elite.[120]

Wildavsky notes in *The Art and Craft of Policy Analysis*, "According to the Great Equation, Medical Care equals Health. But the Great Equation is wrong. More available medical care does not equal better health."[121] The author points out that the medical system normally affects about 10% of common health measures such as infant mortality, adult mortality and sick days. That leaves about 90% determined by factors like life-style choices (diet, exercise and drug use), social conditions (income and genetics) and environment (water and air quality). Most of these factors, called "life chances" by Weber in his analysis of social power,[122] are not within the control of the medical system and need to be addressed through other channels. The problem is that "past successes lead to future failures" within the system; in other words, when life expectancy increases,

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[120] Zaidi, S. A., "Poverty and disease: Need for structural change." *Social Science & Medicine* 27, no. 2 (1988): 119-127, doi.org/10.1016/0277-9536(88)90321-8.

[121] Wildavsky A. (1979) "Doing Better and Feeling Worse: The Political Pathology of Health Policy," in *The Art and Craft of Policy Analysis,* (London: Palgrave Macmillan, 1979), 284.

[122] Weber, M., *Economy and Society: An Outline of Interpretive Sociology,* (New York: Bedminster Press, 1968), 927.

the system is left with an older and more disabled population that places more demands on the system and increases costs. Each increment of better health then becomes more expensive.[123]

Because of its nature, any system for providing national health care will require trade-offs. In 1994 William L. Kissick proposed the Iron Triangle in his text *Medicine's Dilemmas: Infinite needs versus finite resources*. This model establishes that the trade-offs will be among costs, access and quality of outcomes in health care. According to Kissick, the constraints on this system mean that you can improve one or two of these factors, but the improvements will always be at the expense of the other factors. According to this approach, we have to make choices about what we want: 1) We can improve outcomes, but costs will rise and access decline; 2) we can reduce costs, but that will reduce access and quality of outcomes; or 3) we can improve access, but that will increase costs and reduce quality of outcomes. This approach means that any effective strategy has to balance cost, access and quality of outcomes to provide the greatest good for the greatest number of individuals.[124] Because health care is a wicked problem with no final solution and the US government has limited resources, we need to find a way to do the most good with what we have available at any time. In this way, the government can work for the majority of the people and not just the elite.

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[123] Ibid, 285.

[124] Faerber, A.E., *Contrasting Two Frameworks for Healthcare Strategy*. (Lebanon, NH: The Dartmouth Institute, 2017), n.p., FaerberStoryBoardTripleAim20170929.pdf.

In 2008 Donald Berwick, Thomas Nolan and John Whittington proposed The Triple Aim model through an article in the journal *Health Affairs*.[125] This model proposes optimizing health care performance by attention to three dimensions: 1) Improvement of the health care experience, 2) reduction of per capita costs and 3) improvement of population health. The key to this approach is in simultaneously pursuing all three of these dimensions in order to find the best possible balance between the three. This approach does not explicitly address the question of equity in access, but assumes it as part of the quality dimensions it pursues.[126]

Moffett, et al. conducted a study of trends in non-US health care systems and summarized results over a number of years. The recent trend has been away from complete government single-payer funding of health care and toward greater reliance on the private sector for financing and delivery. These reforms are driven by lower birth rates and rapidly aging populations that will require more health and long-term care in the near future, which is expected to greatly increase costs. Lessons from this research include: 1) Government management does not reduce inefficiency, waste or inequity in delivery; 2) a state or national program of universal insurance coverage will not deliver universal access to high-quality health care; 3) fixing prices for prescription drugs, medical services or medical devices will not meet demand for goods and services or encourage investment in research and development; 4) government-run health care systems will not provide for equal treatment based on class, race, disease condition or

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[125] Berwick, D. M., Nolan, T. W. and Whittington, J., "The Triple Aim: Care, Health, And Cost," *Health Affairs* 27, no.3 (2008): 759-769.

[126] Faerber, A.E., *Contrasting Two Frameworks,* n.p.

station in life.[127] This view suggests that the researchers have little confidence in government and public administration's ability to solve problems in the national health care system. The literature review provides background for Moffit's lessons, which should also become lessons for public administrators. First, government management often runs into bureaucracy problems which make it less efficient than private systems which are more often paid based on accountability, effectiveness and efficiency. Second, practitioners prefer to locate in larger cities, leaving rural and minority communities poorly served. Third, fixing prices on goods and services always causes a reduction in supply because suppliers drop out of the market when they cannot make the profits they want to stay in business; this leads to unsatisfied demand for the goods and services. And last, government-run systems will not really provide for equal treatment for all because of the complexities of the system of privilege, poverty, race, age and gender. The authors mean that we cannot look to a one-size-fits-all government solution to cover health care needs. Instead, we need creative solutions to meet particular needs like low-income, lack of transportation, rural or inner city residence, and similar barriers to access.

Public administrators can always try to improve equity, but real-world conditions mean this will be an ongoing challenge. Because health care is a wicked problem with no real solution, public administrators will need to make choices about what tradeoffs will provide the best results for costs, access and outcomes for poor and minority populations. This may vary by program and by region, among other factors, so it is likely no overall

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[127] Moffit, R., Breyer, F., Mani, P., Belien, P., Green D. and Hjertqvist, J., *Perspectives on the European Health Care Systems: Some Lessons for America,* (Washington, D.C.: The Heritage Foundation, 2001), n,p.

national solution will be available. Reviewing the opportunities and challenges of the US health care system, some prospects for reform do emerge.

CHAPTER 5

Conclusions

The purpose of this study is to look at the causes of reduced access, high costs and poor outcomes in the current US health care system, especially as this affects the structure of economic barriers that keep individuals from moving out of poverty and into higher socioeconomic classes, and how the issues of access, costs and outcomes might be addressed through public administration tools and policy. If we are to consider that the major goals of the US health care system should be lowering costs and improving access and outcomes for the poor and minorities, then three major opportunities emerge from this research. These are all methods of addressing the problems through public administration tools and policy, in accordance with the purpose of the study.

First, high costs and low efficiency need to be addressed through streamlining administrative requirements. Woolhandler and Himmelstein,[128] Reinhardt, Hussey and Anderson[129] and Hanson[130] pointed out that much of the costs associated with the current US system have to do with complexity in the various incompatible records, benefits and billing systems. Some of this might be simplified on the local level or through regulation of insurance procedures, but much of the complexity comes from the unplanned nature of the health care system's growth and development on a national level. Efforts at reform

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[128] Woolhandler, S. and Himmelstein, D. U., "The Deteriorating Administrative Efficiency of the US Health Care System." *New England Journal of Medicine,* 324 (1991): 1253-1258, doi: 10.1056/NEJM199105023241805.

[129] Reinhardt, U.E., Hussey, P.S. and Anderson, G.F., "U.S. Health Care Spending in an International Context," *Health Affairs* 23, no. 3 (2004): n.p., doi.org/10.1377/hlthaff.23.3.10.

[130] Hanson, S. H., "The Problems with the U.S. Healthcare System," *Physicians Practice,* 2017, n.p.

like the ACA have often introduced even more bureaucratic complexity into the structure. This means the system is overdue for a major evaluation and overhaul, perhaps through George W. Bush's recommended national electronic health records (EHR) system.[131] The application of advanced technology to the problem could go a long way toward automating routine functions and reducing the huge administrative overhead for record-keeping and billing. Funds freed up by this reduction in costs could be applied to expanding access and services to low-income and minority populations.

Next, elimination of waste to reduce costs needs to be a priority, as recommended by Starfield,[132] Lubin,[133] Zimlichman[134] and others. Some of this comes from inefficiency, for example, when different providers order the same tests because of inefficient record sharing; some comes from fear of liability, when doctors call for unnecessary tests or treatment just in case; some comes from illnesses caused by providers or medical procedures; and last, some comes from provider schemes that extract more payments from the system, on the one hand, or extend to outright fraud on the other. Some improvements might be implemented by improved regulation, but most of this has to do with intelligent controls on the local level, where public administrators monitor and make cost-effective and patient-centered decisions about what should be done to improve health care for all. Again, the application of advanced technology for

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[131] Ibid, n.p.

[132] Starfield, B., "Is US Health Really the Best in the World?" 483.

[133] Lubin, G., "50 Depressing Facts," n.p.

[134] Zimlichman, E., Henderson, D., Tamir, O., Franz, C., Song, P., Yasmin, C.K., Keohane, C, Denham, C.R. and Bates, D.W., "Health Care–associated Infections: A Meta-analysis of Costs and Financial Impact on the US Health Care System." *JAMA Internal Medicine* 173, no. 22 (2013):2039-2046, doi:10.1001/jamainternmed.2013.9763.

records monitoring would help in this case, as a national system would make identification of duplicate and unnecessary orders easier to identify.

Last, policy makers and policy implementers like public administrators need to look at the results from researchers like Betancourt, Green and Carrillo,[135] Williams, Costa, Odunlami and Mohammed[136] and Blaxter[137] that link equity in health attainment to socio-economic position. These researchers suggest that more emphasis on public health through providing better nationwide socio-economic equity will reduce the strain placed on the system by uninsured families and individuals. They also indicate that providing better access to resources like clean water, sanitation, housing, education, addiction programs and nutrition will reduce levels of chronic, infectious and communicable diseases. These factors in disease levels are all heavily dependent on income,[138] and can be controlled by improving the socio-economic status of minorities and the poor within US society through support of reforms such as education and employment opportunities.

As pointed out by Osborne, public administrators have to commit to collaborative relationships between organizations, politics and policy networks in order to implement beneficial change within the system. Successful public administrators have to focus on

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[135] Betancourt, J.R., Green, A.R. and Carrillo, J.E., "Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care." *Public Health Reports,* 118, no. 4 (2003): 293-302, doi.org/10.1093/phr/118.4.293.

[136] Williams, D.R., Costa, M.V. Odunlami, A.O. and Mohammed, S.A., "Moving Upstream: How Interventions that Address the Social Determinants of Health Can Improve Health and Reduce Disparities," *Journal of Public Health Management Practice* 14 (2008): S8-17, doi:10.1097/01.PHH.0000338382.36695.42.

[137] Blaxter, "Health Services as a Defense," 1139.

[138] Zaidi, S. A., "Poverty and disease: Need for structural change." *Social Science & Medicine* 27, no. 2 (1988): 119-127, doi.org/10.1016/0277-9536(88)90321-8.

what Freeman calls the "Principle of Who or What Really Counts."[139] This means creating approaches and arrangements that support accountability, communication and sustainable outcomes for the patients in the US health care system, and working for the majority of the population and not just the elite.[140] One option for government is to offer grants for creative solutions. As public administrators, we can also look for ways to encourage the free market to provide regional and community-based solutions. For example, a number of drug stores in the US now offer health clinics.[141] Some fire departments are moving into health care services.[142] Also, in 2018 Amazon, Berkshire Hathaway and JP Morgan Chase announced a joint venture to provide creative solutions in health care for their 1.2 million employees.[143] In accordance with the stated goals, the results of this study suggest that more research needs to be done to identify creative and innovative solutions like these that public administrators can use to make changes in the US health care system to provide better lower costs, better access and better outcomes for low income and minority populations.

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[139] Freeman, *Strategic Management,* n.p.

[140] Osborne, S., *The New Public Governance*, 125.

[141] Nisen, M., "The American Health Care System Should Be Terrified of the Rise of the Pharmacy Clinic," *Business Insider*, 2013.

[142] Kardish, C., "Fire Departments Shift Their Focus to Medical Care," *Governing,* 2014.

[143] Terry, M., "The Amazon, Berkshire Hathaway, JP Morgan Chase Healthcare Joint Venture Now Named Haven," *Biospace,* 2019.

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